

# AADE Position Statement

## Cultural Sensitivity and Diabetes Education: Recommendations for Diabetes Educators

### Introduction

Diabetes in the United States is a serious public health problem that disproportionately affects African Americans, Hispanics, Asians and Pacific Islanders, American Indians, and Alaskan Natives.<sup>1</sup> People from such culturally diverse populations comprise more than 50% of the US population.<sup>2</sup> This increasingly diverse population has heightened challenges facing health care providers who strive to provide optimal diabetes care to these vulnerable groups.<sup>3</sup> Reasons postulated to explain this disproportionate burden of diabetes include genetic predisposition, family history, improper diet, limited physical activity, and the complex interaction between ethnicity, socioeconomic position, gender, access to quality health care, and overall health status.<sup>3-6</sup> Furthermore, the role of the environment—both physical (eg, restaurants serving healthy foods, walking trails, safe neighborhoods) and social (eg, families, workplaces, social support)—contributes to cultural norms, views, and perspectives that establish rules for living that extend to cultural meaning of disease and its management.<sup>4,7</sup>

### Background

Respecting lay perspectives and health beliefs about diabetes across ethnic and racial groups allows appreciation for illness explanations in context with their ongoing experiences with illness and their adjustment to its management.<sup>5</sup> This approach diverges from a more conventional approach to diabetes treatment that holds the notion that more biomedically “correct” diabetes knowledge should translate into better diabetes care.<sup>5,6</sup> The growing body of literature with regard to culture, medicine, and health heightens the importance of cultural influences, values, and norms on not only food selection

This is an official position statement of the American Association of Diabetes Educators (AADE). AADE is a multidisciplinary professional membership organization of health care professionals dedicated to integrating successful self-management as a key outcome in the care of people with diabetes and related conditions.

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but also every aspect of disease management.<sup>7</sup> Failure to incorporate important aspects of culture into direct patient care and diabetes education targeting ethnically diverse populations may result in less than optimal patient satisfaction in these populations.<sup>8</sup> Resnicov et al<sup>9</sup> advocate that increasing the opportunities for successful patient outcomes will require thoughtful consideration of a number of factors including an individual's and community's ethnic/cultural characteristics, experiences, norms, values, behavioral patterns, and beliefs, as well as historical, environmental, and social forces in the design, delivery, and evaluation of targeted health education materials and programs.

Resnicov et al<sup>9</sup> also advocate that incorporating these factors into targeted health education materials and programs will help meet their definition of cultural sensitivity. These authors assert that cultural sensitivity has 2 dimensions: (1) surface structure, which involves the matching of printed materials and messages to observable, superficial characteristics of a population, and (2) deep structure, which involves the influence of historical experiences and environment (social and physical) underlying psychological forces that influence health behaviors. While surface structure focuses on superficial characteristics such as skin color and language spoken to traditionally examine differences in how racial and ethnic groups initiate and maintain lifestyle practices, it is deep structure that determines the efficacy of a program. Deep structure gets to the salience of the work and to what is learned and connected with in terms of core values, true community participation, and ownership.

## **Conclusion**

The need for individual persons and organizations to become more culturally sensitive and develop deeper connections with people and communities is based in part on the understanding of the role culture plays in cognition and in mediating behavior.<sup>10</sup> Integral to health, culture profoundly affects the way people define and experience health and disease. For example, people diagnosed with diabetes make decisions about health-seeking behaviors, food selection, level of physical activity,<sup>11,12</sup> use of prescription and over-the-counter drugs,<sup>13</sup> and patient-provider interactions based on their cultural perspective.<sup>14</sup> Similarities and differences between and among ethnic groups are manifested in their life experiences; family backgrounds; individual beliefs, attitudes, and practices;

socioeconomic status; environmental surroundings and perception; and experience of racism.<sup>14</sup> These similarities and differences between and among ethnic groups must be understood and considered when designing, delivering, and evaluating primary or secondary focused lifestyle interventions. This is particularly the case given that culturally appropriate interventions greatly affect adoption and maintenance of healthy behaviors over time.

Diabetes educators, their organizations, and collaborating partners (eg, state and federal agencies, other organizations) should evaluate their efforts to understand and explain the roles that culture and ethnicity play in the causes, consequences, delivery, and receptivity of diabetes care. The American Association of Diabetes Educators (AADE) endorses the delivery of culturally relevant services and collaboration with communities to build culturally appropriate interventions.

The code of ethics for AADE calls for diabetes educators to "respect and uphold basic human rights" and "respect the uniqueness, dignity, and autonomy of each individual."<sup>15</sup> This offers a good starting point for exploring the importance of cultural sensitivity in diabetes education, for respect is "the single most powerful ingredient in nourishing relationships and creating a just society," as Sara Lawrence-Lightfoot, author of *Respect: An Exploration*, has said.<sup>16</sup> She offers 6 elements of respect—dialogue, attention, curiosity, healing, empowerment, and self-respect—all well known to diabetes educators. Relying on any of these 6 elements of respect to build cultural competence and cultural sensitivity may require a high degree of vulnerability. Diabetes educators may need to reflect on how "learning-specific contributions such as educational experiences, practice settings, ethnic backgrounds, acquired knowledge, language skills, recognition that culture is important, and awareness of potential personal biases" predict and shape cultural competence and sensitivity.<sup>3</sup>

## **Recommendations**

In maintaining AADE's commitment to promoting optimal diabetes education and patient counseling, the following recommendations relative to incorporating cultural sensitivity are proposed. Diabetes educators are encouraged to

- develop a basic understanding of key terminology such as *cultural sensitivity*, *cultural competence*, *multicultural*, *cultural tailoring*, *racial identity*, and *ethnic identity* (see sidebar);

## Definitions

*Cultural sensitivity:* The extent to which ethnic/cultural characteristics, experiences, norms, values, behavioral patterns, and beliefs of a target population's relevant historical, environmental, and social forces are incorporated in the design, delivery, and evaluation of targeted health promotion materials and programs.<sup>9</sup>

### Cultural sensitivity has 2 primary dimensions:

1. Surface structure involves matching intervention materials and messages to observable, "superficial" (although important) characteristics of a target population. For audiovisual materials, this may involve using people, places, language, music, food, product brands, locations, and clothing familiar to and preferred by target audience. It includes identifying what channels and settings are most appropriate. Surface structure refers to the extent to which interventions meet the target population where they are: how well they "fit" within their culture and experience. Viewed as analogous to face validity of psychological measures, surface structure is a necessary but insufficient prerequisite for construct validity.<sup>7</sup>
2. Deep structure can be more elusive and has received less attention. This requires understanding the cultural, social, historical, environmental, and psychological forces that influence the target health behavior in the proposed target population. Whereas surface structure generally increases the receptivity or acceptance of messages, deep structure conveys salience and thus has much more effect on the actual effectiveness of programs.<sup>7</sup>

*Cultural competence:* "Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious or social groups."<sup>15</sup>

*Multicultural:* The appreciation and incorporation of multiple race/ethnic groups without assumptions of superiority or inferiority. In this sense, culturally competent individuals and culturally sensitive interventions are implicitly multicultural.<sup>7</sup>

*Cultural tailoring:* The process of creating culturally sensitive interventions, often involving the

adaptation of existing materials and programs for racial/ethnic subpopulations.<sup>7</sup>

*Racial identity:* Generally refers to physical characteristics of individuals to include skin color, facial features, hair, and so forth used to define race categories (eg, white, African American, Native American, Asian).

*Ethnic identity:* Refers to how individuals self-identify based on not only physical characteristics but also religious background, nationality, and cultural experience.

- practice active listening, which may permit identification of what is meaningful to people<sup>17</sup>;
- become familiar with cultural variations in families, health beliefs, socioeconomic status, residential settings, and work of the patient with diabetes and his or her family members to expose patterns of community practice as well as medical practice that enhance or undermine good diabetes management<sup>18</sup>;
- respect and understand how their patients, as members of an ethnic group, view themselves, regardless of how the group is classified or viewed by others;
- ensure at a minimum that important aspects of surface structure are addressed when developing diabetes educational materials;
- acknowledge and accept responsibility to identify and use strategies to eliminate personal biases that can influence interactions with ethnic groups other than their own;
- use a collaboration care model that places emphasis on principles of community participation in the design of diabetes self-management practices;
- become involved in continuing education to gain familiarity with the various cultural competency models and their application in diabetes education;
- ensure that patients receive effective, understandable, and respectful care provided in a manner compatible with their cultural health beliefs, practices, and preferred language;
- participate and/or support original research exploring the relationship between culture, health, and medicine; and
- use findings from research exploring the relationship between culture, health, and medicine in diabetes education to develop new therapeutic approaches to improve diabetes care.

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